STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	08/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELL OAKS TERRACE	4200 WYNTREE DR NEWBURGH, IN47630

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R0000	This visit was for Investigation of Complaints IN00094368, IN00094485, IN00094417, and IN00094001. Complaint IN00094368 - Substantiated. State residential deficiencies related to the allegations are cited at R116, R117, R119, and R145. Complaint IN00094485 - Substantiated. State residential deficiencies related to the allegations are cited at R90, R91, and R121. Complaint IN00094417 - Substantiated. State residential deficiencies related to the allegations are cited at 145. Complaint IN00094001 - Substantiated. State residential deficiencies related to the allegations are cited at R144 and R145. Unrelated deficiencies cited. Survey dates: 8/11, 8/12, and 8/15/11 Facility number: 004903 Provider number: 004903 AIM number: N/A Survey team: Jennie Bartelt, RN	R0000	Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Census bed type: Residential: 46 Total: 46 Census payor type: Other: 46 Total: 46 Sample: 15 These state residential findings are cited in accordance with 410 IAC 16.2-5. Quality review completed 8/19/11 Cathy Emswiller RN			

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R0090	(g) The administrator is responsible for the overall management of the facility. The responsibilities of the administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the: (A) employee's full name; and (B) dates and hours worked during the past twelve (12) months. (5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a			

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	notice posted of their availability. (6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request Based on record review and interview, the facility failed to ensure the Administrator reported an allegation of abuse to the State agency, as required in facility policy, for 1 of 1 resident alleged to have been abused in a sample of 15. (Resident G) Findings include: During confidential interview on 8/11/11, the interviewee indicated hearing Hospice Aide #4 verbally threaten Resident G while providing care. The hospice clinical record for Resident G was reviewed on 8/12/11 at 1:00 p.m. Documentation on the Hospice Aide Visit Note indicated the resident was provided personal care by Hospice Aide #4 on 7/4, 7/11, 7/12, 7/18, 7/25, and 8/1/11. The notes indicated routine personal care was provided on all dates except on the note for 7/25/11. A notation on that date indicated, "Pt [patient] was on the floor when I came into room to do care. He refused all care due to not feeling well from being on floor for awhile." During interview on 8/12/11 at 1:15 p.m.,	R0090	**Citation #1 R 090 410 IAC 16.2-5-1.3 (g) (1-6) Administration and Management What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident G's incident was reported onto the Indiana State Department of Health by the Designee appointed by the Residence Director. An investigation was completed of the alleged event and was found to be unsubstantiated. Arrangements were made for an alternative caregiver to provide services to this Resident G. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and Wellness Director were re-educated to the Indiana state ruling 090 410 IAC 16.2-5-1.3 (g)	09/20/2011

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	upon request for files of allegations of abuse, Residence Director (RD) #2, who was from a sister facility and filling in for RD #1 that day, indicated she had contacted RD #1, a corporate representative filling in as Residence Director until Residence Director #3 becomes a licensed Health Facility Administrator. RD #2 indicated RD #1 told her the facility had received no allegations of abuse. During interview on 8/12/11 at 2:05 p.m., RD #2 was advised of the allegation of verbal threatening of Resident G. RD #2 indicated she would investigate the allegation and provide the facility's policy related to allegations of abuse. During interview on 8/12/11 at 4:20 p.m., RD #2 indicated she had talked with the Marketing Director about the allegation. RD #2 indicated she was told the former Wellness Director (WD #2) had come to the Marketing Director's office on an unidentified date and told the Marketing Director that Hospice Aide #4 had threatened Resident G. RD #2 indicated the Marketing Director told RD #2 she had talked with Hospice Aide #4 about the allegation and learned the following: Hospice Aide #4 told the Marketing Director Resident G raised his fist and threatened her, and Hospice Aide #4 said		(1-6) Administration and Management and our policy and procedure regarding the Assisted Living Decision requirements as to reporting of incidents. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director or Designee will perform an ongoing daily review of incident reports per our policy regarding the ALC Decision Tree for a period of six months to ensure incidents are reported to the appropriate individuals and state agencies within twenty four (24) hours of the occurrence as defined within Indiana state ruling 090 410 IAC 16.2-5-1.3 (g) (1-6) Administration and Management. Audits will be reviewed after six months through Bell Oaks Terrace QA process to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of our monitoring plan. **By what date will the systemic changes be completed?** Compliance Date: Sept 20, 2011	

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	she was not hateful but firm with Resident G, as is required in order to care for the resident. Hospice Aide #4 indicated she knew how to manage the resident, since she was a former facility employee. RD #2 indicated Hospice Aide #4 had been at the facility on this date, 8/12/11, to provide care. RD #2 indicated the Marketing Director said she told the former WD she should report to RD #1 if she still had concerns about the allegation. RD #2 indicated neither the Marketing Director nor WD #2 reported the allegation of abuse to RD #1, no investigation of the allegation was made, and the allegation was not reported to the State agency. RD #2 indicated if an RD was not in building, the WD would be in charge of receiving allegations of abuse. The employee file for WD #2 was reviewed on 8/11/11 at 1:30 p.m. The file indicated the WD's date of hire was 7/21/11. Documentation failed to indicate WD #2 received orientation related to policies and procedures related to resident abuse. During interview on 8/11/11 at 12:20 p.m., in regard to employees, RD #1 indicated WD #2 was on staff from 7/21 through 7/27/11, when she did not return to work. The facility's Suspected Abuse/Neglect/Exploitation policy was			

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	provided by RD #2 on 8/12/11 at 4:20 p.m. The policy included, "1. Any complaints of abuse, neglect or exploitation should be viewed as very serious and must be reported to the Residence Director and the Regional Director of Operations immediately....4. If abuse, neglect, or exploitation of a resident is suspected, act immediately to protect the resident from additional harm....Call your Residence Director and Regional Director of Operations for assistance as soon as possible. 5. Act quickly to gather pertinent information....6. Complete an Incident Report and make appropriate documentation in the resident's Service Notes. 7. Initiate an investigation. All staff on duty at the time the alleged abuse occurred must be interviewed prior to leaving their respective shift....8. Upon instruction from your Residence Director or Regional Director of Operations, contact the appropriate State agency as soon as possible during the require reporting timeframe....9. Notify the resident's family/significant other(s) and physician of the suspected or alleged abuse....." This state residential finding is related to Complaint IN00094485.			

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R0091	(h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.			
	Based on interview and record review, the facility failed to implement policy and procedure for protecting residents' rights related to an allegation of abuse of a resident for 1 of 1 resident who was alleged to have been threatened in a sample of 15. (Resident G) Findings include: During confidential interview on 8/11/11, the interviewee indicated hearing Hospice Aide #4 verbally threaten Resident G while providing care. The hospice clinical record for Resident G was reviewed on 8/12/11 at 1:00 p.m. Documentation on the Hospice Aide Visit	R0091	**Citation #2 R 091 410 IAC 16.2-5-1.3 (h) (1-4) Administration and Management What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Resident G's incident was reported onto the Indiana State Department of Health by the Designee appointed by the Residence Director. An investigation was completed of the alleged event and was found to be unsubstantiated. Arrangements were made for an alternative caregiver to provide services to this Resident G. **How the facility will identify**	09/20/2011

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	Note indicated the resident was provided personal care by Hospice Aide #4 on 7/4, 7/11, 7/12, 7/18, 7/25, and 8/1/11. The notes indicated routine personal care was provided on all dates except on the note for 7/25/11. A notation on that date indicated, "Pt [patient] was on the floor when I came into room to do care. He refused all care due to not feeling well from being on floor for awhile." During interview on 8/12/11 at 1:15 p.m., upon request for files of allegations of abuse, Residence Director (RD) #2, who was from a sister facility and filling in for RD #1, indicated she had contacted RD #1, a corporate representative filling in as Residence Director until Residence Director #3 became licensed. RD #2 indicated RD #1 told her the facility had received no allegations of abuse. During interview on 8/12/11 at 2:05 p.m., RD #2 was advised of the allegation of verbal threatening of Resident G. RD #2 indicated she would investigate the allegation and provide the facility's policy related to allegations of abuse. During interview on 8/12/11 at 4:20 p.m., RD #2 indicated she had talked with the Marketing Director about the allegation. She indicated the Marketing Director told her the former Wellness Director (WD #2)		**other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and Wellness Director were re-educated to the Indiana State ruling R 091 410 IAC 16.2-5-1.3 (h)(1-4) Administration and Management and our policy and procedure regarding The Assisted Living Decision. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director or Designee will perform an ongoing daily review of resident incident reports per our policy and procedure regarding the ALC Decision Tree for a period of six months to ensure incidents are reported to the appropriate individuals and state agencies within twenty four (24) hours of the occurrence as defined within Indiana state ruling 090 410 IAC 16.2-5-1.3 (g) (1-6) Administration and Management. The Wellness Director and/or Residence Director will review incidents to ensure resident rights are protected against alleged	

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	had come to the Marketing Director's office and told the Marketing Director that Hospice Aide #4 had threatened Resident G. RD #2 indicated the Marketing Director told RD #2 she had talked with Hospice Aide #4 about the allegation and learned the following: Hospice Aide #4 told the Marketing Director Resident G raised his fist and threatened her, and Hospice Aide #4 said she was not hateful but firm with Resident G, as is required in order to care for the resident. Hospice Aide #4 indicated she knew how to manage Resident G, since she was a former facility employee. RD #2 indicated Hospice Aide #4 had been at the facility on this date, 8/12/11, to provide care. RD #2 indicated the Marketing Director said she told the former WD she should report to RD #1 if she still had concerns about the allegation. RD #2 indicated neither the Marketing Director nor WD #2 reported the allegation of abuse to RD #1, no investigation of the allegation was made, and the allegation was not reported to the State agency. RD #2 indicated if the RD was not in building, the WD would be in charge of receiving allegations of abuse. The employee file for WD #2 was reviewed on 8/11/11 at 1:30 p.m. The file indicated the WD's date of hire was 7/21/11. Documentation failed to indicate		occurrences of abuse through an internal investigation with necessary provisions made as to protect our residents against alleged violations of their resident rights. Audits will be reviewed after six months through Bell Oaks Terrace QA process to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of our monitoring plan.**By what date will the systemic changes be completed?** Compliance Date: Sept 20, 2011	

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	WD #2 received orientation related to policies and procedures related to resident abuse. During interview on 8/11/11 at 12:20 p.m., in regard to employees, RD #1 indicated WD #2 was on staff from 7/21 through 7/27/11, when she did not return to work. The facility's Suspected Abuse/Neglect/Exploitation policy was provided by RD #2 on 8/12/11 at 4:20 p.m. The policy included, "1. Any complaints of abuse, neglect or exploitation should be viewed as very serious and must be reported to the Residence Director and the Regional Director of Operations immediately....4. If abuse, neglect, or exploitation of a resident is suspected, act immediately to protect the resident from additional harm....Call your Residence Director and Regional Director of Operations for assistance as soon as possible. 5. Act quickly to gather pertinent information....6. Complete an Incident Report and make appropriate documentation in the resident's Service Notes. 7. Initiate an investigation. All staff on duty at the time the alleged abuse occurred must be interviewed prior to leaving their respective shift....8. Upon instruction from your Residence Director or Regional Director of Operations, contact the appropriate State agency as			

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	soon as possible during the require reporting timeframe....9. Notify the resident's family/significant other(s) and physician of the suspected or alleged abuse....." This state residential finding is related to Complaint IN00094485.			
R0116	(a) Each facility shall have specific procedures written and implemented for the screening of prospective employees. Appropriate inquiries shall be made for prospective employees. The facility shall have a personnel policy that considers references and any convictions in accordance with IC 16-28-13-3. Based on record review and interview, the facility failed to ensure employment references were checked for prospective employees for 5 of 7 former employees hired and terminated from employment since 4/22/11. (RN Wellness Director #1, CNA #1, CNA #3, Personal Service Attendant #1, RN Wellness Director #2) The deficient practice had the potential to affect 46 of 46 residents at the facility. Findings include:	R0116	**Citation #3 R 116 410 IAC 16.2-5-1.4 (a) Personnel What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Employee files were reviewed for current employees with reference checks completed and placed within their file. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	09/20/2011

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	During Entrance Conference with Residence Director (RD) #1 on 8/11/11 at 10:30 a.m., files of employees terminated, either voluntarily or involuntarily, since 4/1/11 were requested. During interview on 8/11/11 at 10:30 a.m., RD #1 provided files of seven employees terminated since 4/1/11. Review of the files at this time indicated employment or personal references were not checked on the following employees prior to employment: 1. RN Wellness Director #2, date of hire 7/21/11. 2. CNA #1, date of hire 6/22/11. 3. CNA #3, date of hire 6/8/11. 4. PSA (Personal Services Assistant) #1, date of hire 6/10/11. 5. RN Wellness Director #1, date of hire 5/2/11. During interview at this same time, RD #1 indicated she was the Regional Residence Director for fourteen facilities in her corporation, including residences in Tennessee, Kentucky, and Indiana. She indicated the RD from Bell Oaks had been transferred to another facility and had		**taken?** No other residents were found to be affected. Employee files were reviewed for current employees with reference checks completed and placed within their file. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and Wellness Director were re-educated to our policy and procedure regarding new employee paperwork along with completion of reference and background checks for prospective employees prior to hire. The Residence Director, Wellness Director, and/or Designee will be responsible for completing reference checks on new employees prior to resident contact. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/or Designee will perform a random monthly audit of employee files for a period of six months to ensure criminal background and reference checks are completed on prospective employees as indicated within our policy and procedure. Audits will be reviewed after six months through Bell Oaks Terrace QA process to determine the need for an ongoing monitoring plan.	

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	subsequently left the company's employment. She indicated she had a provisional Health Facility Administrator's license for Indiana and had been filling in at Bell Oaks for about four months. She indicated as consultant for fourteen homes, it was hard to keep up. During this same interview, RD #1 indicated PSA #1 had not actually been terminated but was suspended recently related to unusual behavior, and that he would probably be terminated. This state residential finding is related to Complaint IN00094368.		Findings suggestive of compliance will result in cessation of our monitoring plan. **By what date will the systemic changes be completed?** Compliance Date: Sept 20, 2011	

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		A. BUILDING 00 B. WING	08/15/2011

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R0117	(b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on record review and interview, the facility failed to ensure nursing staff was qualified for 2 of 2 licensed nurses on the work schedule for 7/31 through 8/13/11 (LPNs #1 and #2) and 10 of 10 certified nursing assistants on the same work schedule. (CNAs #5, #6, #7, #8, #9, #10, #11, #12, #13, and #14) The facility also failed to ensure the RN Wellness Director was licensed when working for 1 of 2 former RN Wellness Directors. (RN Wellness Director #1) The deficient practice had the potential to affect 46 of	R0117	**Citation #4 R 117 410 IAC 16.2-5-1.4 (b) Personnel What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Employee files were reviewed with verification provided as to their current employee licensure status. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	09/20/2011

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	46 residents at the facility. Findings include: The facility's staffing schedule for 7/31 through 8/13/11 was provided by Residence Director (RD) #1 at the completion of the Initial Tour on 8/11/11 at 11:20 a.m. Nursing staff scheduled to work or observed working at the facility during this time frame included the following: LPNs #1 and #2, CNAs #5, #6, #7, #8, #9, #10, #11, #12, #13, and #14. During interview on 8/12/11 at 11:40 a.m., RD #2, who was from a sister facility and filling in for RD #1 on that day, indicated in her facility she had all information on licensing and certification of nursing staff in a book with current licensing information. RD #2 indicated she was unable to locate the information at Bell Oaks. RD #2 provided internet printouts, dated 8/12/11, indicating all staff listed were licensed or certified. RD #2 also provided the following: 1. For LPN #1, a printout indicating the nurse's licensing information was checked 7/13/09 on-line, and copy of a license card indicating the license expired on 10/31 of even years. The nurse worked from		**taken?** No residents were found to be affected. Employee files were reviewed with verification provided as to their current employee licensure status. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and Wellness Director were re-educated to our policy and procedure regarding new employee paperwork along with completion of licensure verification for prospective employees. The Residence Director and/or Designee will be responsible for ensuring licensure verification is obtained for employees and placed within their prospective employee file. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/or Designee will perform a random monthly audit of employee files for a period of six months to ensure staff have verification of active Indiana licensure within their employee file. Audits will be reviewed after six months through Bell Oaks Terrace QA process to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of our monitoring plan **By what date will the systemic**	

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	10/31/10 until 8/12/11 without evidence of current LPN license. 2. For former employee RN Wellness Director #1, with date of hire 5/2/11, a printout indicating the nurse's license was checked on-line on 6/8/11, and copy of a license card indicating the license expired on 10/31 of odd years. The RN Wellness Director worked 5/2/11 through 6/8/11 without evidence she was a licensed RN. 3. For LPN #2, a printout indicating the nurse's licensing information was checked 5/25/10 on-line, and copy of a license card indicating the license expired on 10/31 of even years. The nurse worked from 10/31/10 until 8/12/11 without evidence of current LPN license. 4. For CNA #9, copy of a licensing card with "VOID" printed five times per column on three columns on the card. No documentation indicated CNA #9 was certified, prior to the on-line printout dated 8/12/11. This state residential finding is related to Complaint IN00094368.		**changes be completed?** Compliance Date: Sept 20, 2011	

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R0119	(d) Prior to working independently, each employee shall be given an orientation to the facility by the supervisor (or his or her designee) of the department in which the employee will work. Orientation of all employees shall include the following: (1) Instructions on the needs of the specialized populations: (A) aged; (B) developmentally disabled; (C) mentally ill; (D) dementia; or (E) children; served in the facility. (2) A review of the facility's policy manual and applicable procedures, including: (A) organization chart; (B) personnel policies; (C) appearance and grooming policies for employees; and (D) residents' rights. (3) Instruction in first aid, emergency procedures, and fire and disaster preparedness, including evacuation procedures. (4) Review of ethical considerations and confidentiality in resident care and records. (5) For direct care staff, personal introduction to, and instruction in, the particular needs of each resident to whom the employee will be providing care. (6) Documentation of the orientation in the employee's personnel record by the person supervising the orientation.			
	Based on record review and interview, the facility failed to ensure employees received orientation to the facility and that documentation of the orientation was maintained in the employee files for 7 of 7 former employees hired and terminated	R0119	**Citation #5 R 119 410 IAC 16.2-5-1.4 (d) (1) (A-E) (2) (A-D) (3- Personnel What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected.	09/20/2011

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	from employment since 4/22/11. (RN Wellness Director #2, CNA #1, CNA #2, CNA #3, CNA #4, PSA #1, RN Wellness Director #1) The deficient practice had the potential to affect 46 of 46 residents at the facility. Findings include: During Entrance Conference with Residence Director (RD) #1 on 8/11/11 at 10:30 a.m., files of employees terminated, either voluntarily or involuntarily, since 4/1/11 were requested. During interview on 8/11/11 at 10:30 a.m., RD #1 provided files of seven employees terminated since 4/1/11. Review of the files at this time indicated lack of orientation and documentation of orientation as follows: 1. RN Wellness Director #2, date of hire 7/21/11, lacked orientation and documentation of orientation to all required aspects except mechanical orientation completed by the Maintenance Supervisor. 2. CNA #1, date of hire 6/22/11, lacked orientation and documentation of orientation to all required aspects except resident rights.		Employee files were reviewed with building specific orientation provided to current staff and placed within their prospective employee file. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No residents were found to be affected. Employee files were reviewed with building specific orientation provided to current staff and placed within their prospective employee file. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and Wellness Director were re-educated to our policy and procedure regarding new employee paperwork along with completion of building specific orientation. The Residence Director and/or Designee will be responsible for ensuring building specific orientation is completed for employees and placed within their prospective file. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/or Designee will perform a random monthly audit of employee files for a period of six months to ensure staff	

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	3. CNA #2, date of hire 4/22/11, lacked orientation and documentation of orientation to all required aspects except the mechanical orientation, signed by the employee on 4/22/11, a former Residence Director on 5/5/11, and a trainer whose signature was not legible on 5/5/11. 4. CNA #3, date of hire 6/8/11, lacked orientation and documentation of orientation to all required aspects of orientation. 5. CNA #4, date of hire 4/28/11, lacked orientation and documentation of orientation to all required aspects of orientation. 6. PSA (Personal Services Assistant) #1, date of hire 6/10/11, lacked orientation and documentation of orientation to all required aspects of orientation. 7. RN Wellness Director #1, date of hire 5/2/11, lacked orientation and documentation of orientation to all required aspects of orientation except for job specific orientation. During interview at this same time, RD #1 indicated she was the Regional Residence Director for fourteen facilities in her corporation, including residences in Tennessee, Kentucky, and Indiana. She		have building specific orientation completed and placed within their employee file. Audits will be reviewed after six months through Bell Oaks Terrace QA process to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of our monitoring plan **By what date will the systemic changes be completed?** Compliance Date: Sept 20, 2011	

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	indicated the RD from Bell Oaks had been transferred to another facility and had subsequently left the company's employment. She indicated she had a provisional administrator's license for Indiana and had been filling in at Bell Oaks for about four months. She indicated as consultant for fourteen homes, it was hard to keep up. During this same interview, RD #1 indicated PSA #1 had not actually been terminated but was suspended related to unusual behavior, and that he would probably be terminated. This state residential finding is related to Complaint IN00094368.			

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R0121	(f) A health screen shall be required for each employee of a facility prior to resident contact. The screen shall include a tuberculin skin test, using the Mantoux method (5 TU, PPD), unless a previously positive reaction can be documented. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered. The facility must assure the following: (1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis. The first tuberculin skin test must be read prior to the employee starting work. For health care workers who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed one (1) to three (3) weeks after the first step. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (2) All employees who have a positive reaction to the skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. (3) The facility shall maintain a health record of each employee that includes reports of all employment-related health screenings. (4) An employee with symptoms or signs of active disease, (symptoms suggestive of active tuberculosis, including, but not limited to, cough, fever, night sweats, and weight loss) shall not be permitted to work until tuberculosis is ruled out. Based on record review and interview, the facility failed to ensure employees	R0121	**Citation #6 R 121 410 IAC 16.2-5-1.4 (d) (1) (A-E) (2) (A-D) (3- Personnel What corrective**	09/20/2011

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	received health assessments, including skin testing for tuberculosis, for 7 of 7 former employees hired and terminated from employment since 4/22/11. The deficient practice had the potential to affect 46 of 46 residents at the facility. Findings include: During Entrance Conference with Residence Director (RD) #1 on 8/11/11 at 10:30 a.m., files of employees terminated, either voluntarily or involuntarily, since 4/1/11 were requested. During interview on 8/11/11 at 10:30 a.m., RD #1 provided files of seven employees terminated since 4/1/11. Review of the files at this time indicated the following employees did not have health assessments and/or skin tests for tuberculosis (TB) prior to employment: 1. RN Wellness Director #2, date of hire 7/21/11 - no evidence of health assessment or TB skin test 2. CNA #1, date of hire 6/22/11 - no TB skin test. 3. CNA #2, date of hire 4/22/11 - no health assessment and no TB skin test. 4. CNA #3, date of hire 6/8/11 - no health		**action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Employee files were reviewed with completion of health assessments, including skin testing for tuberculosis and placed within their employee file. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. Employee files were reviewed with completion of health assessments, including skin testing for tuberculosis and placed within their employee file. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and Wellness Director were re-educated to our policy and procedure regarding employee health screening, including skin testing for tuberculosis. The Wellness Director has developed and implemented a tickler book containing employee health screens, including mantoux skin test to ensure continued compliance. **How will the corrective action(s) will be monitored to ensure the**	

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	assessment, first step of TB skin test on 6/21/11, no second TB skin test. (CNA #3 was listed on the schedule as a housekeeper for 10 days on the daily schedule from 7/31/11 through 8/13/11.) 5. CNA #4, date of hire 4/28/11 - no health assessment and no TB skin test. 6. PSA (Personal Services Assistant) #1, date of hire 6/10/11 - no second step TB skin test. (PSA #1's last date scheduled for work was 8/7/11 on the schedule from 7/31/11 through 8/13/11.) 7. RN Wellness Director #1, date of hire 5/2/11 - no health assessment. During interview at this same time, RD #1 indicated she was the Regional Residence Director for fourteen facilities in her corporation, including residences in Tennessee, Kentucky, and Indiana. She indicated the RD from Bell Oaks had been transferred to another facility and had subsequently left the company's employment. She indicated she had a provisional administrator's license for Indiana and had been filling in at Bell Oaks for about four months. She indicated as consultant for fourteen homes, it was hard to keep up. During this same interview, RD #1 indicated PSA #1 had not actually been terminated but		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Designee will perform a random monthly audit of employee tickler file for a period of six months to ensure continued compliance. Audits will be reviewed after six months through Bell Oaks Terrace QA process to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of our monitoring plan **By what date will the systemic changes be completed?** Compliance Date: Sept 20, 2011	

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	was suspended related to unusual behavior, and that he would probably be terminated, pending investigation. During interview on 8/11/11 at 3:00 p.m., RD #1 indicated the Wellness Director is responsible for TB testing, and some have "fallen through the cracks." This state residential finding is related to Complaint IN00094485.			
R0144	(a) The facility shall be clean, orderly, and in a state of good repair, both inside and out, and shall provide reasonable comfort for all residents. Based on observation and interview, the facility failed to ensure residents' rooms were clean and in good repair for 5 of 5	R0144	**Citation #7 R 144 410 IAC 16.2-5-1.5 (a) Sanitation and Safety Standards What corrective action(s) will be**	09/20/2011

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	residents whose rooms and bathrooms were inspected from a sample of 15. (Residents F, K, L, N and M) Findings include: Environmental observations on 8/15/11 from 4:15 to 4:55 p.m., were as follows: 1. In the bathroom of Resident F, smears of a brown substance were observed on the floor in front of the toilet. Crumbs and scuffed dirt were on the floor of the bathroom. 2. In the bathroom of Resident K, the trash can was full to overflowing with soiled pull-ups. The seat and inside of the toilet were soiled with a brown substance. A large dead bug was on the floor beside the toilet. Between the open window and screen of the window near the bed, a green-black substance was observed on the window facings. 3. In the room of Resident L, gouges into the drywall above the baseboard near the closet were observed. Pieces of drywall littered the carpet. The carpet was soiled with unvacuumed debris. In the resident's bathroom, the toilet was smeared on the outside and seat with a brown substance. Debris on the floor in front of the toilet was covered with live, moving ants. No		**accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Residents F, K, L, N, and M had their rooms professionally cleaned and repaired. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. Residents F, K, L, N, and M had their rooms professionally cleaned and repaired. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and Wellness Director were re-educated to our policy and procedure pertaining to cleaning of resident apartments and the Indiana state ruling R 144 410 IAC 16.2-5-1.5 (a) Sanitation and Safety Standards. The Residence Director will be responsible to ensure continued compliance with resident cleaning of apartments per our Residency Agreement. The House keeper has developed and implemented a room cleaning list to be completed and reviewed with the Residence Director and/or Designee to ensure cleaning prior to end of shift. **How will the corrective action(s) will be monitored to ensure the**	

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	toilet paper was available on the roller or beside the toilet. 4. In the bathroom of Resident M, the coating on the floor of the shower was chipped and peeling. A trash bag was draped over the side of the trash can holding the bathroom door open. The interior of the trash can was soiled with splotches of a brown substance. The floor of the bathroom, especially in front of the toilet and sink, was dull gray with scuffs. 5. The carpet in Resident N's room was stained black in front of the television, in an area about 2 feet by 3 feet. The carpet by the bed and in front of the resident's recliner was stained with large dark splotches. The floor of the resident's bathroom was a dull gray. On 8/15/11 at 4:55 p.m. Residence Director (RD) #2 arrived at the facility, and shortly after RD #3 arrived. RD #3 observed the area on the facings between the window and screen of Resident K's window near the bed. During interview at this time, RD #3 indicated the substance looked like mildew. RD #3 wiped an area on the window sill inside the room and indicated it was dirty. RD #3 observed the bathroom floor in Resident M's room and indicated the dull gray was worn out linoleum. RD #3 indicated the floors		**deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/or Designee will perform random weekly review of apartments cleaned by the housekeeper for a period of six months to ensure continued compliance with room cleanliness per our expectation. Audits will be reviewed after six months through Bell Oaks Terrace QA process to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of our monitoring plan **By what date will the systemic changes be completed?** Compliance Date: Sept 20, 2011	

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		A. BUILDING 00 B. WING	08/15/2011

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	were not waxed, because residents might fall. This state residential finding is related to Complaint IN00094001.			
R0145	(b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the needs of the residents. Based on observation, record review, and interview, the facility failed to ensure equipment was in date and supplies were sufficient for meeting residents' needs for 2 of 5 residents reviewed wearing Wanderguard alert bracelets (Residents O and P) and 46 of 46 residents whose care required the use of gloves/trash can liners. Findings include: 1. On 8/11/11 at 11:20 a.m., the employee file for PSA (Personal Services Assistant) #1 indicated correspondence including, but not limited to, an unsigned notation for 8/6/11 indicating, "[Name of PSA #1], ...We have discussed the sufficient supplies of garbage bags and gloves and	R0145	**Citation #8 R 145 410 IAC 16.2-5-1.5 (b) Sanitation and Safety Standards What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Residents O & P had new wander guards ordered and placed on residents. The wander guard system was tested and found to be operational. The Residence ordered trash can liners and gloves for staff utilization. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. Residents O & P had new wander guards ordered and	09/20/2011

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	that you are to ask for them when cleaning and they will be supplied to you...." Another memo, from the corporation's Director of Human Resources to Residence Director #3 (unlicensed) with carbon copy to Residence Director #1 (Health Facility Administrator of record) indicated, "...Please let him know we have a sufficient supply of garbage bags and gloves...." During interview in regard to the gloves and trash can liners, Residence Director (RD) #1 indicated the facility was without gloves and trash can liners on one day. RD #1 indicated she herself went to (a local department store) and purchased gloves and liners on that day. RD #1 indicated at that time she had an AIT (Administrator in Training) working with her, who was responsible for supply orders, and he had not ordered needed supplies. During interview with Confidential Interviewee #1 on 8/11/11, the interviewee indicated the facility had no gloves for resident care on the first day of the job. Confidential Interviewee #1 indicated gloves were purchased personally by the interviewee for use in the facility. During interview with Confidential		placed on residents. The wander guard system was tested and found to be operational. The Residence Director and/or Designee will be responsible for ensuring ordering of resident supplies is completed timely and that trash can liners and gloves are available for staff providing resident care. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Residence Director and Wellness Director were re-educated to our wander guard system and techniques to ensure it is functioning properly. The Residence Director and/or Designee will be responsible to ensure the wander guard system is operational. The Residence Director will also be responsible for ordering of supplies for caregivers and to ensure availability for resident care. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/or Designee will perform random monthly review of wander guard system and caregiver supplies for a period of six months to ensure the wander guard system is functioning properly and caregiver supplies are available for staff providing care for a period of three months to ensure	

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	Interviewee #2 on 8/11/11, the interviewee indicated the facility had no gloves for providing residents' personal care, and the facility was without gloves for about three weeks in July 2011. Confidential Interviewee #2 indicated gloves were sometimes borrowed from residents receiving home health or hospice services for provision of care to other residents. During interview with Confidential Interviewee #3 on 8/11/11, the interviewee indicated there had been more than one day when the facility was without gloves. Confidential Interviewee #3 indicated there were several days they were without gloves or trash can liners. During observation in the rooms of Residents F, K, and G on 8/15/11 between 4:15 p.m. and 4:55 p.m., the following sign in bold lettering was posted on the walls of the residents' rooms: "All supplies (gloves, creams, diapers, wipes, chucks, etc.) are paid for by hospice. Do not use these on other patients. Thank you. [Name], RN." During interview on 8/15/11 at 4:55 p.m., RD #2 indicated the signs were posted on this date, and no one indicated why the signs were posted. RD #2 indicated the hospice nurse had not spoken to her about		continued compliance. Audits will be reviewed after six months through Bell Oaks Terrace QA process to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of our monitoring plan **By what date will the systemic changes be completed?** Compliance Date: Sept 20, 2011	

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	the signs. 2. During interview on 8/12/11 at 2:05 p.m., in regard to the facility's Wanderguard system, the Marketing Director indicated she checks dates on the Wanderguards for residents, and the alarm is good until the expiration date. The Marketing Director was asked to check the Wanderguard for Resident O, who was seated at this time in the residence foyer near the facility's alarmed front door. The Marketing Director indicated she knew the alarm was good, because she had just heard it sound to alert staff the resident was near the front door. Observation of the alarm at this time indicated an expiration date of 8/10. The Marketing Director indicated the alarm was out of date and needed to be changed. The Marketing Director provided a list of five residents, including Resident O, who used the Wanderguard alarm system. Observations were made of all the residents' Wanderguard bracelets, and Resident P's bracelet was also observed to be out of date with an expiration date of 8/10. This state residential finding is related to Complaints IN00094368, IN00094417, and IN00094001.			

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R0214	(a) An evaluation of the individual needs of each resident shall be initiated prior to admission and shall be updated at least semiannually and upon a known substantial change in the resident ' s condition, or more often at the resident ' s or facility ' s request. A licensed nurse shall evaluate the nursing needs of the resident. Based on record review and interview, the facility failed to ensure a licensed nurse attended to the nursing need for assessment after falls for 2 of 2 residents reviewed related to falls in a sample of 15. (Residents B and F) Findings include: 1. The clinical record for Resident B was reviewed on 8/11/11 at 2:55 p.m. Resident Services Notes on 7/13/11 at 9:00 p.m. indicated, "Res. [resident] was found sitting on the side of her bed - states she slid off the bed side - walker in B/R [bathroom]. P [pulse] 80 209/82 [blood pressure] 98.6 [temperature] 80 [pulse] 24 [respirations]. [Symbol for no] apparent injuries noted @ this X [time]. Family notified - Dr. [name] notified - recording received - message - incident report fax to Dr. office. Res. lying in bed @ this X." The note was signed by the Qualified Medication Aide [QMA #1].	R0214	**Citation #9 R 214 410 IAC 16.2-5-2 (a) Evaluation What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Residents B & F have had their service plans updated to reflect interventions to minimize the risk for falls with injury. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. Residents considered at risk for falls were reviewed with their service plans updated to include interventions to minimize the risk for falls with injury. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director and licensed nursing staff were re-educated to	09/20/2011

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	Documentation in the Resident Services Notes failed to indicate a nurse was notified or assessed the resident. 2. The clinical record for Resident F was reviewed on 8/11/11 at 3:15 p.m. Resident Services Notes on 7/27/11 at 7:40 p.m., indicated, "Res was found on floor - side of bed - sts [states] she's [symbol for not] in pain ROM [range of motion] performed [[symbol for no] apparent injuries noted VS [vital signs]...." The note also indicated the physician, family , hospice provider, administrator and nursing staff RN were notified. The note was signed by QMA #1. Documentation in the Resident Services Notes failed to indicate a nurse assessed the resident. During interview on 8/12/11 at 5:10 p.m., Residence Director (RD) #2, from a sister facility and filling in for RD #1, indicated she would expect a resident to be sent out for evaluation at the time of a fall, if the resident hit the head, or if an emergency was evident, 9-1-1 would be called. RD #2 indicated in other situations, the nurse on call is expected to come into assess a resident who falls. RD #2 indicated if the resident is on the floor, he should remain on the floor until the nurse arrives, but if the resident insists on getting up, the nurse should assess the resident as soon as she arrives on site.		our policy and procedure regarding our fall response and protocol. The Wellness Director and/or Designee will evaluate residents who are considered at risk for falls to ensure interventions are noted on the service plans in order to minimize the risk for falls with injury. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Designee will perform random weekly review of incident reports and the service notes for a period of six months to ensure residents who experience a fall and/or change of condition are assessed by a licensed nurse to ensure they have appropriate interventions noted on their service plans to minimize the risk for a potential adverse event. Residents will be assessed by the Wellness Director on a routine basis utilizing our Nursing Comprehensive Assessment in order to evaluate and formulate a plan to minimize the risk for a potential adverse event based on the assessment of the individuals scheduled and unscheduled needs. Audits will be reviewed after six months through Bell Oaks Terrace QA process to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of our monitoring plan	

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R0217	(e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope; (B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided.			
	Based on record review and interview, the facility failed to ensure the resident's service plan was signed by the resident or responsible party. The facility also failed to ensure a nurse participated in planning services for residents who required nursing care. The deficient practice	R0217	**Citation #10 R 217 410 IAC 16.2-5-2 (e)(1-5) Evaluation** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. Residents	09/20/2011

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	affected 4 of 6 residents whose service plans were reviewed related to signatures (Residents C, D, B, and E), and 1 of 6 residents whose service plans were reviewed related to nurse participation (Resident C) in a sample of 15. Findings include: 1. The clinical record for Resident C was reviewed on 8/11/11 at 4:05 p.m. The most recent service plan, dated 8/8/11, was signed by Residence Director (RD) #1. No signature of the resident/responsible party or nurse was indicated. The plan indicated the resident received nursing services including dressing changes and medication administration. 2. The clinical record for Resident D was reviewed on 8/11/11 at 3:35 p.m. The most recent service plan, dated 7/6/11, was signed by RD #3, the Residence Director in Training, and a nurse. No signature of the resident/responsible party was indicated. 3. The clinical record for Resident E was reviewed on 8/11/11 at 2:15 p.m. The most recent service plan, dated 5/11/11, was signed by an AIT [Administrator in Training] and a nurse. No signature of the resident/responsible party was indicated.		C, D, B, and E had their service plans reviewed by the interdisciplinary team with plans implemented to meet these clients scheduled and unscheduled needs. are met. The service plans were signed by the appropriate parties as indicated within our policy and procedure. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director and Residence Director were re-educated to our policy and procedure regarding the service level assessment and negotiated service plan. The Residence Director will ensure the service level assessment is signed by the appropriate parties as indicated within our policy and procedure. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Residence Director and/or Designee will perform random weekly reviews of service assessments for a period of six months to ensure appropriate interventions are discussed through	

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	4. The clinical record for Resident B was reviewed on 8/11/11 at 2:55 p.m. The most recent service plan, dated 5/5/11, was signed by the AIT and the former RN Wellness Director #1. No signature of the resident/responsible party was indicated. On 8/15/11 at 5:20 p.m., RD #2, RD #3, and the RN Wellness Director #3, whose first day on the job was 8/15/11, were observed in the nurse's station looking through binders and stacks of documents. During interview at this time, RD #3 indicated other copies of the service plans might be in the nurse's station, but no copies were found. RD #3 indicated Resident D's sister signs for him, but had not signed the most recent plan.		our interdisciplinary team with appropriate signatures obtained for a period of six months. Audits will be reviewed after six months through Bell Oaks Terrace QA process to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of our monitoring plan **By what date will the systemic changes be completed?** Compliance Date: Sept 20, 2011	
R0241	(e) The administration of medications and the provision of residential nursing care shall be as ordered by the resident ' s physician and shall be supervised by a licensed nurse on the premises or on call as follows: (1) Medication shall be administered by licensed nursing personnel or qualified medication aides. Based on observation, record review and interview, the facility failed to ensure nursing care and medications were administered as ordered by the physician for 2 of 6 residents reviewed related to	R0241	**Citation #11 R 241 410 IAC 16.2-5-4 (e)(1) Health Services** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** Resident C had the	09/20/2011

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	physician's orders in a sample of 15. (Residents F and C) Findings include: 1. During observation of personal care on 8/12/11 at 10:20 a.m., CNAs #5 and #12 assisted Resident F to the toilet. As the CNAs assisted the resident to remove her brief, runny yellow stool was observed on the brief. The resident was seated on the toilet and defecated again. During interview at that time, CNA #12 indicated the resident had often had diarrhea for quite some time, and she wondered if maybe the resident's medications caused the diarrhea. The clinical record for Resident F was reviewed on 8/11/11 at 3:15 p.m. The record indicated an order was received 7/8/11 by the hospice nurse for Immodium 2 mg by mouth after each loose stool for a maximum of 16 mg per day. On 7/22/11 a physician's order, still current for August 2011, indicated, "Immodium 2 tab TID [three times daily] prn [as needed] for diarrhea." The MAR for August 2011 indicated the resident had received no doses of the Immodium during that month. During interview on 8/15/11 at 5:20 p.m.,		dressing changes clarified with the hospice nurse with documentation to be provided as to the scheduled dressing changes as ordered by the physician. Resident C was assessed utilizing the pain assessment scale with physician notification as to appropriate pain management. Resident F had the medication regimen reviewed with the licensed staff as to appropriate intervention to be implemented with episodes of loose stools. Resident F's physician was also notified by the Wellness Director of the episodes of loose stools for possible intervention. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make to ensure that the deficient practice does not recur?** The Wellness Director and licensed staff were re-educated to our policy and procedure regarding our Medication Administration Record, medication administration, and documentation. The Wellness Director will ensure the medication administration record and service notes indicate medications and treatments are	

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	QMA #1 indicated it had been three or four weeks since Resident F had Immodium. RN Wellness Director #3 looked at the Medication Administration Record and indicated the resident had Immodium most recently on 7/16/11. 2A. During observation of personal care for Resident C on 8/12/11 at 10:35 a.m., the resident was observed to have dressings on the right and left shins and on a coccyx wound. None of the dressings were dated for the date of most recent dressing change. The clinical record for Resident C was reviewed on 8/11/11 at 4:05 p.m. A physician's order, dated 7/21/11 and received by the hospice nurse included, but was not limited to, "...start dressing [symbol for change] to L [left] anterior leg & R [right] anterior leg skin tears as followed [sic]: Cleanse [symbol for with] NS [normal saline] or wound cleanser, apply TAO [triple antibiotic ointment], cover with Telfa & secure [symbol for with] paper tape q [every] day until healed." The Treatment Administration Record for July 2011 failed to indicate the dressing change had been completed to the right and left legs.		administered as indicated within the physicians order. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Designee will perform random weekly review of the Medication Administration Record and the service notes for a period of six months to ensure medications and treatments are administered as indicated by the physician for a period of six months. Audits will be reviewed after six months through Bell Oaks Terrace QA process to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of our monitoring plan.**By what date will the systemic changes be completed?** Compliance Date: Sept 20, 2011	

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A hospice nurse's note, dated 7/28/11, indicated, "Reviewed dressing [symbol for change] orders with [name of LPN #1]....No dressing [symbol for change] has been done since last HRN [hospice registered nurse] visit. [LPN #1] agreed to address matter...."

2B. During the observation of personal care for Resident C on 8/12/11 at 10:35 a.m., CNAs #5 and #12 indicated she "just didn't want to be bothered." CNA #12 indicated it hurt the resident when they moved her. The resident was observed to squeeze CNA #5's fingers and not want to let go as she was rolled from side to side for personal cleansing. As the resident was moved up in bed, she grimaced, moaned, and said, "You don't know how bad that hurts."

Resident C's physician orders for August 2011 included the following medications for pain: Oxycontin, 10 mg, twice daily; Tylenol, 325 mg, two tablets every four hours as needed for pain; and Oxycodone HCl 20mg/ml solution, 0.25 ml (5 mg) by mouth or under the tongue every hour as needed for pain or shortness of breath.

The August 2011 Medication Administration Record indicated neither of the "as needed" medications had been

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		A. BUILDING 00 B. WING	08/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	administered in August 2011.			
R0407	(b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review and interview, the facility failed to ensure the planned infection control tracking mechanism was completed timely for analyzing patterns of infections. The deficient practice has the potential to affect 46 of 46 residents in the facility. Findings include: During review of the Medication Administration Record binder on 8/11/11 at 2:20 p.m., blank documents were indicated in the binder. A completed document for May 2011 was indicated in the binder. The documents were titled, "Infection Tracking," and handwritten on	R0407	**Citation #12 R 407 410 IAC 16.2-5-4 (e)(1) Health Services** **What corrective action(s) will be accomplished for those residents found to have been affected by this deficient practice?** No residents were found to be affected. The infection control log was implemented for August by the Wellness Director as indicated within the form. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** No other residents were found to be affected. **What measures will be put into place or what systemic changes will the facility make**	09/20/2011

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	each document was: "Please make note of any new abx [antibiotic] below. Month: [on one blank document was June Yr: 2011; on one was July Yr: 2011, and on a third was: August Yr: 2011]." During observation in the nurse's station on 8/11/11 at 4:40 p.m., LPN #1 was observed completing the blank logs for June, July, and August, 2011. During interview at this time, LPN #1 indicated she had just completed the logs for tracking infections. During interview on 8/11/11 at 5:00 p.m., Residence Director (RD) #1 indicated LPN #1 had just completed the logs for the past three months with information by reviewing short term change in condition reports. RD #1 was requested to provide the facility's current Infection Control policies. The facility's policy for Infection Control was requested and was provided on the conference room table on 8/12/11 at 9:15 a.m. The policy failed to describe the system for how infections were to be tracked.		**to ensure that the deficient practice does not recur?** The Wellness Director and licensed staff were re-educated to our policy and procedure regarding our infection control log to ensure we are tracking and trending the infectious processes identified on a monthly basis. The Wellness Director will be responsible to ensure the infection control log is updated when residents are identified as having an infection. **How will the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Wellness Director and/or Designee will perform a random weekly review of the Infection Tracking Log to ensure continued compliance for a period of six months. Audits will be reviewed after six months through Bell Oaks Terrace QA process to determine the need for an ongoing monitoring plan. Findings suggestive of compliance will result in cessation of our monitoring plan. **By what date will the systemic changes be completed?** Compliance Date: Sept 20, 2011	